

MAR 11 1924

Medical Lib

THE RHODE ISLAND MEDICAL JOURNAL



Owned and Published by the Rhode Island Medical Society. Issued Monthly

VOLUME VII }
No. 3 } Whole No. 174

PROVIDENCE, R. I., MARCH, 1924

PER YEAR \$2.00
SINGLE COPY 25 CENTS

CONTENTS

ORIGINAL ARTICLES

Acne Vulgaris,	Roy Blosser, M. D.	33
Calcification and Bone Formation in the Adrenals,	A. R. Newsam, M. D.	35
Address,	Charles E. Donlon	38

Contents continued on page IV advertising section

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE AT PROVIDENCE, R. I., UNDER ACT OF MARCH 3, 1879

Suprarenalin Solution

A fine product in a convenient package

SUPRARENALIN SOLUTION
1:1000 is the incomparable preparation of the kind. It keeps well and is put up in a g. s. bottle with cup stopper. By working from the solution in the cup, contamination of the con-

tents of the original package is avoided. Ischemic action of Suprarenalin Solution is enhanced and prolonged by the addition of equal parts of Pituitary Liquid (Armour), the Premier Product of Posterior Pituitary.

SUPRARENALIN OINTMENT 1:1000
is very bland and its effects lasting

ARMOUR AND COMPANY

CHICAGO



**We Are Headquarters
For The Endocrines**

MEAD'S

BETTER BABIES

There is a difference between *PROPER NOURISHMENT* for the baby and — just some kind of food

SUCCESS

Physicians agree that successful infant feeding begins with

BREAST MILK

Pediatricists are constantly furnishing newer knowledge on

Prolonged Lactation
Reestablishment of Breast Milk after the Breast is Dry
Overfeeding
Underfeeding
Colic of Breast Nursed Infants
Instructions to Mothers at time of Baby's Birth
Retracted and Spastic Nipples
Premature Infants
Lack of Education of Mothers

These data will be found in our pamphlet entitled:

"BREAST FEEDING AND THE REESTABLISHMENT OF BREAST MILK"

EQUIPMENT

When Breast milk is not obtainable the following equipment furnished by MEAD will aid the physician to obtain gratifying results in artificial infant feeding:

MEAD'S PEDIATRIC TOOL KIT

contains File Index of Corrective Diets, Weight Charts, Prescription Blanks, History Charts, Diets for Older Children, Instructions for Expectant Mothers, Pedigreed and Certified Cod Liver Oil, Dextri-Maltose, Florena, Arrowroot Flour, Oat Flour, Barley Flour, Casec, other helps. This equipment is an aid to the management of the diet of well babies and sick babies and is of great assistance to obtain co-operation from mothers. It is free.

Mead's Infant Diet Materials assist the physician to obtain CONTROL and eliminate CONFUSION

The Mead Johnson Policy

Mead's Infant Diet Materials are advertised only to physicians. No feeding directions accompany trade packages. Information in regard to feeding is supplied to the mother by written instructions from her the feedings from time nutritional requirements Literature furnished



to time to meet the needs of the growing infant only to physicians

Mead Johnson & Company, Evansville, Indiana

An Institution Devoted to the Study of Infant Nutrition

Mention our Journal—it identifies you.

THE RHODE ISLAND MEDICAL JOURNAL

The Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

VOLUME VII {
NUMBER 3 { Whole No. 174

PROVIDENCE, R. I., MARCH, 1924

PER YEAR \$2.00
SINGLE COPY 25 CENTS

ORIGINAL ARTICLES

ACNE VULGARIS.

By ROY BLOSSER, M.D.

PROVIDENCE, R. I.

Acne is a common disease in dermatological practice, exceeded only by eczema and syphilis. Until recent years it has been an exceedingly baffling disease to treat, and this probably accounts for the widely prevalent idea that the disease is incurable and that it must be allowed to run its course and get well of its own accord. This does happen in time, but the patient endures years of annoyance and chagrin and the face is often left permanently disfigured by scars.

From the standpoint of general health and strength, acne is not a serious disease, but it is a severe handicap to a young person both in business and in social relations, not only because it produces disfigurement, but also because it renders the individual extremely timid and self conscious.

Etiology.

There seems little doubt that the main exciting cause in the development of the comedo or black-head, and the papule or pustule which follows, is the acne bacillus, first described and named by Unna in 1893 and later by Sabouraud and Gilchrist in 1897. These bacilli invariably are found present in the comedo, and it is claimed by Sabouraud¹ that they alter the character of the oily secretion or sebum which, with the hyperkeratosis of the lining membrane of the pilosebaceous follicle, results in the formation of the comedo. With the formation of the pustule which develops around the comedo there are present various pyogenic staphylococci.

"The comedo is composed of concentrically arranged horny layers like the sheaths of an onion, which are specially dense at the periphery and upper extremity, which is dark in color from the excessive cornification and from pigment. The cen-

tral mass is cheesy and consists of sebaceous material, twisted up lanugo hairs and the debris of horn cells."²

In addition to the acne bacillus there are several predisposing causes: It is a disease of adolescence, rarely beginning before the age of 12 or 14 years and usually subsiding before the age of 30 or 35 years. This is explained by the fact that there is a tendency to over-activity of the sebaceous glands at this time of life; an oily skin seems to be an essential factor in the development of comedones. Another contributory cause in many cases is indigestion and constipation resulting from a diet composed too largely of carbohydrates, especially candy and other sweet foods. But it is impossible to cure acne by abstention from these foods and we are forced to conclude that this is not an essential cause of the disease.

Symptoms and Diagnosis.

In early cases the comedones may be the only lesions present. The skin is excessively oily. Later there will be pustules, small and superficial at first, but tending to become deeper and more indurated as time goes on.

The presence of comedones serves to distinguish acne from other diseases in which a pustular eruption occurs on the face, such as bromide and iodide eruptions, acne varioliformis and the pustular syphilide.

The clinical varieties of acne are named from the predominance of some one type of lesion—acne papulosa, acne pustulosa, acne indurata. Acne cacheticorum or acne scrofulosorum is a rare form of the disease which occurs in individuals of low resistance. It is characterized by deep sluggish pustules or furuncles, markedly indurated.

In some cases of acne, especially the severe types of the disease, the back and shoulders are affected in the same manner as the face. More rarely, lesions occur on the chest and arms. Occasionally a case is seen in which the back alone is involved, the face remaining clear.

Treatment.

Patients with acne should be given a general examination in order to determine whether there is

¹Walker: Introduction to Dermatology. Edinburgh and London, W. Green & Son, p. 195; 1919.

²MacLeod: Diseases of the Skin. London, H. K. Lewis & Co., p. 1027, 1920

any constitutional disorder. Faulty habits of diet should be corrected. Very generally these patients eat too much sweet food, especially candy, ice cream, cake and pastry, and too much fried food. The acne patient, especially at the age when the disease first develops, is a very active person and often resorts to the high caloric sweets and fried foods in an effort to make up for a meal which for him is deficient, but which might be all that is needed for an older person. Three generous and well balanced meals a day and nothing except fruit between meals is, I think, a good rule in most cases.

In girls, particularly, anemia is often present and should be treated; in all cases an outdoor life and plenty of exercise are helpful.

The patient should be instructed to bathe the face in moderately warm water morning and evening, and to rub the soap in with the hands for three minutes. The soap is rinsed off with cold water, witch hazel is applied, and the face is fanned for a few moments before drying. Two or three times a week, with a comedo extractor, the comedones should be extracted and the pustules incised with a sharp pointed knife. Few patients can properly incise a pustule and it is best for the physician to do this; by incising the pustules at an early stage their duration is greatly shortened and scarring is prevented.

Treatment of the Scalp.

If a routine examination of the scalp is made in acne it will be found that there is more or less dandruff in nearly every case; and often the scalp is excessively oily. Both acne bacilli and staphylococci are present in the scales and on the scalp which shows that there is close at hand a constant source of reinfection for the face. The importance of this fact is borne out in practice, for we find that acne is more amenable to treatment if the scalp is treated antiseptically at the same time as the face. The following lotion will be found effective:

Resorcini	drams	1
Acidi salicylici	drams	$\frac{1}{2}$
Hydrarg. chlor. corrosiv	gr.	2
Aquae		
Spts. Vini Rect. a. a.	oz.	3

M. Sig. Apply at night.

For men this can be dispensed in a bottle with a crown stopper. Women should use a dropper or an atomizer in order to get the lotion applied directly to the scalp. It should be gently rubbed in for several minutes after each application. In blondes the resorcin is apt to produce staining of the hair and should be replaced by an equal amount of euresol pro capillis.

The scalp should be washed once a week as a rule, but if the hair is excessively oily twice a week is preferable.

Local Treatment.

In cases of acne which are just beginning, in which comedones are not very numerous and the pustules not indurated it is often possible to effect a cure by the use of a lotion containing sulphur and by following the rules previously given as to diet and the care of the face and scalp. Salves, cold cream and all greasy applications to the face should be avoided in acne. The best form in which to use sulphur is in the following combination:*

Potass. sulphuret	
Zinci sulphatis a. a. sat. sol.	drams 2-4
Misce et ad.	
Sulphur praec.	drams 1-2
Glycerinae	drams 2
Aq. Rosae Q. S. ad	oz. 4

This lotion is applied at night and allowed to remain on until morning. Generally it is best to use the weaker formula first, but after a four-ounce prescription has been used it should be increased to the full strength. The lotion is rubbed into the skin with a piece of cloth wrapped around the finger. This should be done rather gently at first because it is apt to make the skin somewhat dry, but after a week or two it can and should be rubbed in more vigorously.

If after a month or two of treatment there is no improvement, especially as regards the number of

*Unless the pharmacist is experienced in making up this prescription he is not apt to get the ingredients to combine properly. The following directions for compounding were given me by Mr. C. E. Black, Ph.G.: The saturated solution of zinc sulphate and potassium sulphuret must be made separately and mixed slowly. The potassium sulphuret must be fresh. Made in this way the lotion is white and creamy with only a very slight sulphurous odor.

comedones, it is advisable to use X-ray treatment. In chronic and long standing cases the infection is too deep in the skin to be reached by local medication, and the patient usually has become discouraged by the failure of various remedies, internal and external, and by dietary restrictions.

X-Ray Treatment.

In recent years the invention of the Coolidge tube and the discovery by MacKee and his co-workers of a method by which the amount or dose of radiation can be accurately controlled has made X-ray treatment a thoroughly safe procedure and one which is being successfully carried out in many thousands of cases of acne and other chronic skin diseases.

The length of time required to cure a case of acne with the X-ray varies from 10 to 16 weeks. Treatments are usually given at weekly intervals. Little or no improvement is noticed for the first three or four weeks, but soon after this it will be found that the pustules are becoming superficial and less indurated, that the formation of new comedones has lessened or stopped, and that the skin is less oily.

The treatment produces no change whatever in the normal skin because only fractional or tonic doses of X-ray are used, that is, an amount far below that which would be required to produce a change or reaction in normal tissue.

No local applications to the face are used during X-ray treatment except that the face is bathed twice a day as previously described; the same rules as to diet and exercise should be observed and the patient's general health looked after.

Following X-ray treatment if the patient is reasonably careful as to diet and general health there will be no relapse of the disease except in a small percentage of cases. MacKee³ states that the percentage of relapses should not be greater than 5% and that as a rule they are mild and respond promptly to another course of treatment. In my own practice there have been two relapses out of 29 cases treated. One patient wrote from a western city six months after finishing a course of

treatment that the eruption had returned to some degree. Another patient who had a severe indurative type of acne required a second course of treatment 16 months after the first. Ten treatments were required to clear up the face the second time.

There have been no failures. One patient stopped after four treatments because there was no improvement.

The average number of X-ray treatments given the 29 patients was 12.2.

CALCIFICATION AND BONE FORMATION IN THE ADRENALS.

A. R. NEWSAM, M.D.

PROVIDENCE CITY HOSPITAL.

Much experimental work has been done in connection with the adrenals, but in this paper I can mention only a few of the conclusions that seem to be quite definitely established. That the adrenals are essential to the life of most common laboratory animals is quite generally accepted. Of the two portions—cortex and medulla—the latter is apparently essential (Biedl),¹ and others. It is also apparent that animals can live in apparent health, after large portions of both adrenals have been removed (Crowe and Wislocki)², (Whipple and Christman)³, and others. As yet, however, it has been impossible to produce graded symptoms of adrenal insufficiency. Either enough is left to permit the animal to live and develop in an apparently normal way or too much is removed and the animal dies within a short period of time. It would seem, therefore, as stated by Stewart,⁴ that "the anatomical line which separates full physiological sufficiency from fatal insufficiency is very narrow." When all the adrenal tissue is removed certain manifestations become apparent. In brief, Crowe and Wislocki² found that dogs were apparently normal for several hours after operation. Soon, however, they began to show loss of appetite, muscular weakness, gradual increasing drowsiness,

References.

- ¹Biedl, *Innere Sekretion*, 1913, I Teil, p. 313-534.
- ²Crowe, S. J., and Wislocki, Geo. P., *J. H. Hospital Bulletin*, Vol. XXV., No. 284.
- ³Whipple, G. H., and Christman, J. *Exp. Med.* 1914, '20.
- ⁴Stewart, G. N., *Endocrinology*, Vol. V., 238.

³MacKee: *X-Rays and Radium in the Treatment of Diseases of the Skin*. Philadelphia and New York, Lea & Febiger, p. 309, 1921.

lowering of body temperature, muscular rigidity, tremors (in some cases tremors disappeared if the animal was wrapped in a warm blanket and the body temperature restored to normal), lowering of blood pressure, and in a number of cases convulsive seizures were noted. General convulsive seizures were apparently independent of body temperature and at post-mortem no brain lesions were found.

Bearing these facts in mind, this case and the case reported by Victor⁵ are of interest.

Johanna R., white, female, age 2 yrs. 7 mos., was admitted to the Children's Hospital, Boston, on Aug. 23, 1923.

The family history was essentially negative.

The past history. The patient was a full term baby, weighing 8½ pounds and was delivered by forceps. There was, however, no evidence of injury at birth and nothing abnormal about the child was noticed during the first few months of life.

She was breast fed for 1½ yrs., then gradually weaned on a table diet.

Her developmental history was essentially normal, the first tooth erupting at 6 mos. She talked at 9 mos. and walked at 13 mos.

When a little more than one year old she developed pertussis, followed by measles and bronchitis. These infections were mild and with uncomplicated recoveries.

She had at no time in her life any symptoms referable to upper respiratory infections, cardiac, pulmonary, gastric or genito-urinary disturbances. Her appetite had always been fair and her bowels always moved regularly.

She had at no time recently been exposed to any acute contagious disease.

The present illness: The mother dates the onset of the child's present illness to the evening of Aug. 21, 1923, when the little girl ate an entire ice-cream cone shortly before going to bed. She, however, slept perfectly well that night and the following day and night appeared as usual.

At 7 A. M. Aug. 23rd (the morning of admission) the little girl awoke, stood up in bed and fell unconscious into her mother's arms. She was at once put into a mustard bath and given an

enema. There was a good result from the enema but consciousness was not regained. At 10 A. M. she had a convulsion, clonic in type, involving all the extremities, the body and the face. She had numerous similar convulsions between 10 A. M. and 12:30 P. M., when she was admitted to the ward. She had been incontinent and had vomited three times. In the intervals between convulsions she remained comatose.

P. E. on admission. The patient was a well developed and well nourished girl lying quietly in bed in a comatose condition with poor color and irregular, rapid, sighing respirations. There was no evidence of paralysis. The temperature was 98.4, pulse 104 and respirations 46.

Head, negative. *Eyes*, the pupils were equal and regular and reacted to light. Examination of the eye grounds showed a slight blurring of both discs. *Ears*, both drums were dull and the land marks partly obliterated. *Schrapnells membrane* was deeply congested on both sides, there was no bulging of the drum membranes. No mastoid tenderness or edema. *Nose*, negative. *Throat*, the tonsils were medium in size and the pharynx and tonsils moderately congested. There was no exudate or membrane present. *Mouth*, the Buccal M.M. were of normal color. The teeth and gums were in good condition. *Chest*, was symmetrical and well shaped and both sides moved equally with respiration. *Heart*, measured 2 cms. to the right of the mid-sternal line and 5 cms. to the left in the fourth interspace. The cardiac sounds were regular and of good quality and volume. The rate was 104 per minute. There were no murmurs. *Lungs*, resonance was normal throughout both lungs and the breath sounds were broncho vascular throughout. There were no rales. *Abdomen*, was scaphoid in type and soft. There was no evidence of tenderness, spasm, rigidity, masses or free fluid. The liver, spleen and kidneys were not palpable. *Reflexes*, the abdominal, patellar, achilles and all the arm reflexes were absent. There was no Kernig, Babinski, ankle clonus, Brudzinski, Chvostek or Trousseau's sign. *Extremities: skin, glands, spine and genillia and anus*, were all entirely negative to examination.

Laboratory Findings: On admission the white blood count was 7,600. Blood pressure systolic 60, diastolic 40.

⁵Victor, M., Ztschr. f. Kinderh., 30:40, Aug. '21.

Lumbar puncture gave a clear fluid under a slightly increased pressure. Negative globulin reduction of Benedict's solution and 3 cells (monos).

Wasserman on the spinal fluid was negative.

Stool examination was negative.

The urine was clear, amber, acid. Sp. grav. 1028. No albumen, sugar, acetone, or diacetic, and the urinary sediment showed nothing abnormal.

Course: From the time of admission at 12:30 P. M., Aug. 23, 1923, until death occurred at 9:15 P. M., Aug. 23, 1923, the child was almost continuously in convulsions which were clonic in type and involving the whole body, the right side of the face, the left arm and left leg being most markedly involved.

At times during these convulsions cyanosis became extreme, the patient frothed at the mouth and had incontinence of both urine and feces. Following one very severe convulsion her abdomen rapidly became markedly distended. Rectal tube did not relieve this condition. She was given a stomach lavage, at the end of which castor oil oz. 1, sodium bromide gr. 10, and chloral gr. 5 were left in the stomach.

In spite of oxygen, cardiac stimulation and sedatives her convulsions continued, her general condition became gradually worse and she died at 9:15 P. M., approximately nine hours after admission.

REPORT OF AUTOPSY.

A complete autopsy was done on this child, but a detailed report of the macroscopic and microscopic findings would occupy too much space, hence only the important positive findings are described.

Adrenals—Macroscopic. On grasping the adrenals after removal, they were found to be firm and nodular, each weighing 3 gms. and each retaining the normal shape, somewhat shrunken in size, but each presenting many pale elevations which form the consistence, and note when struck with the flat of a knife appeared to be calcified material. Inspection of the adrenals indicated that very little of the cortex remained and that the whole of the medulla was replaced by calcified material. It also seemed evident from the gross inspection that there were extensive cicatrices

thinning the middle portion of the adrenal markedly.

Microscopic. The cortex of the adrenals was apparent here and there about the periphery as small nodules of varying size. In places it was entirely missing. In the place where the medulla is normally situated, there were deposits of calcium salts, also spicules of bone and bone marrow containing blood forming cells. In places the deposits of calcium salts were being replaced by bone.

In addition to the positive findings in the adrenal there was some oedema and congestion of the brain and of the lungs, a thymus gland which weighed 20 grams and a rather abnormal prominence of Peyer's patches and the mesenteric lymph nodes.

In this case and another one recorded by Victor⁵, the findings are practically identical.

This is particularly interesting, as it has been noted that dogs deprived of a large portion of their adrenals and permitted to live for a considerable period of time, frequently showed a large thymus and an unusual prominence of lymphoid tissue in the abdomen.²

The absence of pigmentation of the skin was especially noted in both cases. This suggests that pigmentation as observed in Addison's disease must be due to something more than the simple destruction of adrenals, found in both instances.

In Victor's case deposits of calcium salts were found, but in our case, bone and bone-marrow were also found.

In spite of the extreme rarity of bone and bone-marrow formation in the adrenals, we must expect to find bone formation occasionally in very unusual places. Extensive injuries due to hemorrhage or inflammatory lesions are sometimes followed by deposits of calcium salts, and it is a well known fact that in these isolated deposits, bone and bone-marrow sometimes occur.

Wooley⁶ discusses the subject of metaplasia in connection with a case of an adult showing tuberculosis of the lungs and adrenals in which he found bone and bone-marrow in the adrenals.

It would seem that my case presents additional evidence supporting the view that metaplasia ac-

⁵Wooley, Paul G., J. Lab. and Clin. Med., 1:502, April, 1916.

counts for bone formation in such unusual places as the adrenals.

The only evidence of an acute infectious process was found in the tonsils. The condition observed in the germinal centres of lymphoid tissue is a thing seen in many acute infectious diseases and is apparently not characteristic of any one.

From the nature of the process observed it can hardly be doubted that the lesions in the adrenals in both cases must have existed for a long time. It would seem therefore that these two individuals lived and developed in an apparently normal way with adrenals much reduced in size, and from this it seems justifiable to conclude that only small amounts of adrenal tissue are necessary to life. The fact that our patient lived with adrenals in which the medullary portion was almost if not completely destroyed suggests that the medulla may not be essential to life.

The signs and symptoms in both cases have many points in common with experimental adrenal insufficiency produced in dogs by Crowe and Wislocki.² If in man the anatomical line between sufficiency and fatal insufficiency is very narrow, as Stewart⁴ suggests that it is in animals, can we not consider it possible that already extensively injured adrenals might be rendered insufficient by even a slight additional burden produced by an acute infectious process?

ADDRESS.*

By CHARLES E. DONLON

CREDIT MANAGER OF THE BOSTON STORE, PROVIDENCE, R. I.

Mr. Chairman and Members of the Medical Association: I am going to be very brief with this subject. There exists in the minds of a great many people the impression that the professional man who extends credit can conduct his business without the use of ready money, that he can maintain his establishment and take care of its expenses and the expenses incidental to his home without the regular income of money. This has brought about a condition of slow pay and delinquent accounts which has been quite general. It exists to a great extent largely with a line having to do with the general public. It is found in the retail mer-

chandising field. It exists to a great extent in the professions. Doctors, lawyers, dentists, wait longer than merchants for their money. In the retail field it has been an important factor. Merchants generally have had to give it careful consideration. In order that the inflow of money may be kept somewhere proportionate to the outgo, they have had to devise ways and means for collecting this money. Their methods and ways I want to talk about for a few minutes.

Every collection system in the opinion of credit men generally has for its foundation a good bookkeeping system, that is to say, a bookkeeping system that shows the condition of the account, how long standing, whether due or overdue; a simple system of bookkeeping showing the condition of the account at all times. That system of bookkeeping provides for the sending of a monthly bill or statement regularly on some given date during the month. We in the department store business find that a monthly bill is the greatest agency for collecting money that we have yet devised. The major portion of money collected is collected through that medium. Why is it important? What is there about it that has the appeal?

First of all, it goes to the customer when the obligation is new, when the inclination to pay is stronger than it is ever going to be. It serves notice that a certain amount of money is due and payment is expected. When sent out regularly it forms a paying habit and is a big asset in the collection of money. It is the nicest and best, and retains the good will of the customer, and brings in the money. Conservatively, 85% to 90% of all money collected is collected through this simple bill or statement. In order to get the results from it, it is necessary that it be sent regularly on a certain fixed date during the month so that it becomes a part of the customer's business life.

In the offices with which I am connected we mail our bills on the last day of the month, so the customer gets it on the first, and we permit it to stand without any further action until the end of that month. At the end of the month we send the regular monthly statement. If payment is not forthcoming, we send in the middle of the month a special bill or statement. Up to the sixty-day period it is the only method we use. Then the letters start. The letters are worded with a view

*Read before the Providence Medical Association, January 7, 1924.

THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

FREDERICK N. BROWN, M.D., *Editor*
309 Olney Street, Providence, R. I.

CREIGHTON W. SKELTON, M. D., *Business Manager*
266 Broad Street
Providence, R. I.

ASA S. BRIGGS, M. D.
ALEX M. BURGESS, M. D.
W. LOUIS CHAPMAN, M.D.
JOHN E. DONLEY, M. D.
ROLAND HAMMOND, M. D.
J. W. LEECH, M. D.
NORMAN M. MCLEOD, M. D.
ALBERT H. MILLER, M. D.
DENNETT L. RICHARDSON, M.D.
ARTHUR H. RUGGLES, M. D.

*Associate
Editors* *Committee on Publication*

FREDERICK N. BROWN, M.D., *Chairman*
FRANK MEARS ADAMS, M.D.
ARTHUR T. JONES, M.D.
J. A. KING, M.D.
J. W. LEECH, M.D.

Advertising matter must be received by the 10th of the month preceding date of issue.

Advertising rates furnished upon application, to the business manager, CREIGHTON W. SKELTON, M D., 266 Broad Street, Providence, R. I.

Reprints will be furnished at the following prices, providing a request for same is made at time proof is returned: 100, 4 pages without covers, \$6.00; each additional 100, \$1.00. 100, 8 pages, without covers, \$7.50; each additional 100, \$2.80; 100, with covers, \$12.00; each additional 100, \$4.80. 100, 16 pages, without covers, \$10.50; each additional 100, \$3.00; 100, with covers, \$16.00, each additional 100, \$5.50.

SUBSCRIPTION PRICE, \$2.00 PER ANNUM. SINGLE COPIES, 25 CENTS.

Entered at Providence, R. I. Post Office as Second-class Matter.

RHODE ISLAND MEDICAL SOCIETY

Meets the first Thursday in September, December, March and June

ARTHUR T. JONES	<i>President</i>	Providence
WM. F. BARRY	<i>1st Vice-President</i>	Woonsocket
HALSEY DEWOLF	<i>2nd " "</i>	Providence
JAMES W. LEECH	<i>Secretary</i>	Providence
J. E. MOWRY	<i>Treasurer</i>	Providence

DISTRICT SOCIETIES

KENT

Meets the second Thursday in each month

G. HOUSTON	<i>President</i>	Arctic
C. S. CHRISTIE	<i>Secretary</i>	Riverpoint

NEWPORT

Meets the third Thursday in each month

NORMAN M. MACLEOD	<i>President</i>	Newport
ALEXANDER C. SANFORD	<i>Secretary</i>	Newport

Section on Medicine—1th Tuesday in each month, Dr. Charles A. McDonald, Chairman; Dr. C. W. Skelton, Secretary and Treasurer.

R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President Dr. F. Nulton Bigelow, President; Dr. Jeffrey J. Walsh, Secretary-Treasurer.

The R. I. Medico-Legal Society—Last Thursday—January, April, June and October. James B. Littlefield, Esq., President; Dr. Jacob S. Kelley, Secretary-Treasurer.

PAWTUCKET
Meets the third Thursday in each month excepting
July and August

STANLEY SPRAGUE	<i>President</i>	Pawtucket
GEORGE E. RONNE	<i>Secretary</i>	Pawtucket

PROVIDENCE

Meets the first Monday in each month excepting
July, August and September

GEORGE W. VAN BENSCHOTEN	<i>President</i>	Providence
P. P. CHASE	<i>Secretary</i>	Providence

WASHINGTON

Meets the second Thursday in January, April,
July and October

F. E. BURKE	<i>President</i>	Wakefield
WM. A. HILLARD	<i>Secretary</i>	Westerly

WOONSOCKET

Meets the second Thursday in each month excepting
July and August

A. A. WEEDEN	<i>President</i>	Woonsocket
THOMAS S. FLYNN	<i>Secretary</i>	Woonsocket

EDITORIALS

THE BUSINESS MANAGER.

Owing to the resignation of Dr. Frank M. Adams as business manager of the RHODE ISLAND MEDICAL JOURNAL, made necessary by increasing professional responsibilities, it became our duty to assign this work to other hands; as will be seen by glancing over our editorial page, Dr. C. W. Skelton has been gracious enough to accept the post.

While we were reluctant to accept Dr. Adams' resignation, we were fortunate in securing the

services of Dr. Skelton. Dr. Skelton brings to the JOURNAL a considerable experience, an acute business acumen, and unlimited energy. With this combination, the financial future of the JOURNAL affords us happy contemplation.

"GUILTY."

For years the medical profession has been timid about asserting their authority for the care of persons suffering with mental illness. Persons who cannot afford to pay the cost of their care in the State of Rhode Island are being almost daily

taken into the District Courts and there adjudged *guilty* of being insane. A person who can afford to pay for their care can go to a hospital and there be legally held, if a certificate has been signed by two physicians and the request for their admission made by a responsible person. Why the discrimination? If mental disorder is a medical problem in one instance, is it not in the other? The spectacle of a woman, ill with mental disease, being held in a District Court for over two hours, with the doctors waiting all that time to give testimony, and then being taken before a judge into a room in which there are truant officers, probation officers, policemen, sheriffs, small boys, and a number of other persons having nothing whatever to do with the sick woman, is an outrage against sickness which should not longer be tolerated by the medical profession in the State of Rhode Island. The legal profession may say we must guard the inalienable right of personal liberty, but would they be desirous of having individuals with scarlet fever mingling with the general public? Every day persons with contagious diseases are held in the quarantine of home or hospital, and yet a person who happens to be afflicted with a disease of the brain cannot be so quarantined, if they happen also to be afflicted with poverty, unless they are haled into Court.

MILD NEUROSSES.

The general practitioner still remains with us, "the flower of our present civilization, such as it is." To him still falls the peculiar family problems which, so far, no particular specialist has taken up, at least for the great group of people who are not prepared to pay large fees.

The sudden attack of hysteria in the adolescent girl, the ill—or, never to be—sublimated maiden of unquestionable age, the anxiety neurosis of any age from early childhood to senescence and the involution period of women, and men also. All these may be handled very successfully in a great many cases by the family physician, perhaps more successfully on account of the confidence which his association with the family has built up. The quick reply will probably be "Why, bless my soul,

that is just what the family physician has been doing for a thousand years." True, but the point is that in 1924 the hysteria case should not have the hypodermic administration of morphine, the adolescent girl, whose quickening sex impulses are causing a mental conflict because she knows that her secret acts are incompatible with her parents' mid-Victorian code, should not be subjected to gynecological tinkering. Again for the anxiety neurosis or mild neurasthenic states, the administration of *sumbul*¹ and *assafoetida* or such a time-honored combination as iron quinine and strychnia are of doubtful value.

The family physician may not accept the teachings of the Freudian School, but a little reading with no great amount of new terms to master and no outlay for laboratory space and equipment may find a modern conception of certain conditions which he sees daily that will be of great advantage to his patients. He might study the modern meaning of the terms sublimation, subliminal, positive or negative transference, and when he discovers the meaning of autotransference, if he be half way honest with himself, he will perhaps smile, or even blush if he allows himself a little retrospection.

Many cults of healing are establishing themselves daily because they accomplish something for the patient. The unfortunate thing about them is not that they are successes, financially, but that they use unknowingly, crude forms of suggestion whose results are nearly always transient. In this group of patients, one is reminded that if all the drugs were thrown into the sea "so much the worse for the fishes but so much the better for mankind."

And here is the point. When both patient and doctor become dissatisfied with drugs for neuroses, and in this respect the patient is already much more awake to a changed conception of their cause than the average family physician, then the doctor must have ready to offer a new system of treatment. As for gland therapy, take care if you use it that the criticism which is being applied to various mechanical cure alls be not applicable to your new pills. You may use more scientific terms to describe them but they may be no more scientific in effect. Trust the physiologist to apprise you that a certain discovery warrants the belief that a fairly clean cut new specific is available.

THE POOR.

The economic condition of the so-called poor is an ever-present matter with every physician. The conscientious physician makes a survey of conditions each time he enters the home of the lowly and inquires how his patient may have those things of convenience and comfort which make for a restoration of health and also seeks to learn of hygienic shortcomings which perchance may be the cause of the case in hand. And in moments of reflection he wonders what share in the prodigious social activities of the present time has been that bestowed upon the so-called poor and what the past quarter or half century has done to better their condition and improve their physical welfare. On one hand may be arrayed housing conditions, cost of food and fuel and clothing and general hygiene,— on the other those of ill health and discomfort resulting from lack of these features. It is not enough to say the condition of the poor is better, it should be rather how may it still be improved. This brief study may well be limited to the education of children in preparation for wage earning, providing and housing. The room furnishing shelter for from three to ten people is not yet a thing of the past, suitable ventilation and hygienic living is far from universal, economic waste from unwise providing, liquor and gambling is still a very important feature in the economic life of the small wage earner. The cost of living is still a tremendously important matter. None too much is known about the real cost of the necessities of life, the highest possible price and the poorest quality of goods is the real fact of present-day conditions. And while it is quite true that extravagance and foolish waste on non-necessities is very often seen, it is equally true that there is a large proportion of people of very moderate means who buy carefully and who are obliged to spend much money for a very poor quality of clothing, as far as warmth and wear are concerned. Along with the deterioration of quality in clothing is seen that in fuel and food. Again, in the matter of home life is seen the fact that ignorance and not unwillingness is often the cause of hermetically sealed windows, dirty floors, and the improper care and preparation of food. With these indisputable facts in mind we may inquire if our profession has given the attention to this branch of

economics that it deserves, if our school systems are giving to the very young, those influences which shape the mind for system, care and thoughtfulness in the necessities of life and if our nursing organizations are following up cases in the homes and instituting domestic reforms and changes which are needed in individual cases. The suggestion that untidy homes have posted in a conspicuous place a placard, in the language of those who live therein, telling of the value of suitable heating, lighting, ventilation, the necessary hours of rest, of wholesome and economical foods and of general domestic care, together with the price that may have to be paid in ill health by those who do not observe these simple yet very necessary rules, is a good one and might be the means of causing some families to experience hygienic religion. Constant reiteration is good orthodoxy, particularly when it is the exponent of sound teaching.

And these things are not alone for the lowly. The "den" or smoke room of the banker may be overheated and unwholesome. The petted child may not have suitable food or enough fresh air or vitamins. The bejewelled matron may have less air and exercise than the pet dog, and the whole family far less sleep than is necessary to rest and refresh them.

On the whole, it would seem that the poor do very well indeed with the small means at their disposal. When we recall how difficult it is to convince the well to do of the need of following the principles of health and right living, when we review our experience with those who can and will not avail themselves of modern methods of diagnosis and treatment, and who will not contribute to the support of the medicant profession in paying their just and honest bills and who will not apply the simple rules of health and right living in the bringing up of their offspring, it makes one more and more willing to assist the needy whose poverty often makes them desirous of better things and appreciative of efforts in their behalf.

THINK A MOMENT

If our advertisers had no confidence in the theory of reciprocity, there would be blank pages in this Journal.

FORTY YEARS AS SUPERINTENDENT OF HEALTH OF PROVIDENCE.

On the night of January 28, 1924, at the Providence-Biltmore, one hundred of the friends of Dr. Charles V. Chapin gathered from far and near to hold a festival in his honor. Dr. Chapin completed forty years of service as Superintendent of Health of the City of Providence on January 7, 1924.

"We may live so near our great men that we do not realize their dimensions. It is good for us to come together now and then, not to praise the dead, but to appreciate the living. Dr. Chapin is one of the most distinguished living graduates of Brown University and he has made the City of Providence known in the ends of the earth." (President W. H. P. Faunce.)

"It was he who made the first real attempt to put real public health on the basis of science, logic, and common sense. He originated the scientific practice of public health." (Dr. H. W. Hill, Director, Institute of Public Health, London, Canada.)

"The magnificent service which he has rendered to public health during the last forty years is only now beginning to be fully appreciated by the communities throughout the United States." (Dr. Lee K. Frankel, Vice-President, Metropolitan Life Insurance Company.)

"He is today our foremost sanitarian, and no one is more deserving of tributes of respect and admiration from his colleagues and friends than he. Chapin's services and contributions to sanitary knowledge and practice have brought him distinguished reputation here and abroad. He has applied scientific principles in the administrative control of disease, and with keen and sound critical judgment has tested these principles by experience and not hesitated to follow wherever the light of truth led him. He has thus abandoned old paths and struck out new ones when necessary. He has been a leader and pioneer in the field of public health and not only Providence and Rhode Island but the whole country are his debtors." (Dr. William H. Welch, The Johns Hopkins University School of Hygiene and Public Health.)

After dinner, under the able leadership of Dr. G. Alder Blumer, as Toastmaster, the following speakers paid their tributes to Dr. Chapin: Hon-

orable Joseph H. Gainer, Mayor of Providence; Dr. Eugene P. King, Deputy Superintendent of Health of Providence; Dr. Arthur T. Jones, President of the Rhode Island Medical Society; Dr. Milton J. Rosenau, Professor of Preventive Medicine and Hygiene, School of Public Health, Harvard University; Dr. William S. Rankin, Secretary, North Carolina State Board of Health, and Field Director Committee on Municipal Health Department Practice, American Public Health Association; and Dr. Charles J. Hastings, Medical Officer of Health, Toronto, Canada.

Dr. Jones, on behalf of many of the friends of Dr. Chapin, both physicians and laymen, presented him with a silver loving cup, appropriately inscribed, as a slight appreciation of their esteem, and as a memento of the occasion.

Besides the speakers there were present the following guests from out of town: Dr. Francis G. Curtis, Chairman, Board of Health, Newton, Mass.; Dr. Francis P. Denny, Health Officer, Brookline, Mass.; Dr. Louis I. Dublin, Statistician, Metropolitan Life Insurance Company; Dr. Samuel H. Durgin, formerly Superintendent of Health, Boston, Mass.; Dr. Eugene R. Kelley, Commissioner of Health, Massachusetts; Dr. Alan J. McLaughlin, United States Public Health Service; Dr. Victor Safford, Deputy Commissioner of Health, Boston, Mass.; Dr. Francis A. Slack, Massachusetts Institute of Technology; Dr. William F. Snow, American Social Hygiene Association; Prof. George C. Whipple, Harvard University; Prof. C. E. A. Winslow, Yale University.

[The foregoing, received by us from Professor Frederic P. Gorham, is a fitting (though short) commentary upon the achievements of a man of whom Providence is justly proud; while the words are few, the sentiment expressed is large. The quotations noted are, however, only a few of many that found voice upon this occasion, coming from many sources and many quarters, from men eminently qualified to speak authoritatively upon health problems and sanitation, whose intellectuality and knowledge of these affairs place them in the fore rank of the country's best.

THE RHODE ISLAND MEDICAL JOURNAL takes this welcome opportunity to also congratulate Dr. Chapin, and pays tribute to the perspicacity of the various speakers and those who sent greetings from afar; and while it gladdens us to hear that his sterling worth is recognized abroad, we have long known that our quiet, unassuming health officer (if we may paraphrase a bit) is a "Prophet that found honor in his own home."—Ed.]

SOCIETIES

THE RHODE ISLAND MEDICAL SOCIETY.

The President brought up the subject of the investigation of bogus diplomas and stated that the matter had been taken up by the House of Delegates at its last meeting. He further suggested that it was understood that the matter would come up before the regular meeting, in consequence of which he had requested Dr. Richards to be present. The President then suggested that as Dr. Richards was present he would call upon him first, as perhaps he could give us the data on any cases that were under investigation and the status of the subject up to date, feeling that a statement from Dr. Richards might do away with unnecessary questioning from members.

Being called upon, Dr. Richards spoke as follows:

Dr. Byron U. Richards: Very soon after this matter became agitated in the State of Connecticut, I made a review of applications of candidates who had taken examination before the Rhode Island State Board of Health since 1908, in every instance where there has been any deviation on the part of the State Board of Health from its established custom of requiring graduates to be from Class A colleges, and I found there have been eight such instances. In 1918, His Excellency Governor Beeckman telephoned to me one day that he was very anxious for a certain physician to go into the service, that a certain piece of work had been outlined for this man and his services were very much needed as an assistant, and he made the request that the State Board of Health examine this man and that he be given a license to practice medicine in this State. The State Board of Health convened and considered the source of the request and the importance of the matter at that time and that there was a very serious shortage of medical men, not only here but in service; this candidate was examined and after the examination was given a license to practice medicine in this State.

I have made a few notes on the eight cases to which I will refer. This gentleman is marked "G" on my list. He was a graduate from the Mary-

land Medical College in 1913, appeared for examination in 1918, five years later. He was at St. Joseph's Hospital from June, 1913, to July, 1914; and Connecticut State Prison Hospital from August, 1914, to November, 1917. He was given a license to practice medicine on his promise to enter the medical service of the United States Army, which he did, and has continued in that service from that time on.

Very soon after that a physician made application for examination. He came before the Board in uniform. He was a man who had had very excellent experience, as you will note when I read you the record, and it appeared to the Board that consideration of such men should be made. It did not automatically issue licenses to all men in the service, the Board did not take that action, but it did in some cases. Under "C." A physician, a graduate of College of Physicians and Surgeons, Memphis, Tenn., 1911. According to the rating of the A. M. A., this college became extinct in 1911, having a rating of B at that time. This applicant was allowed to take his examination in view of his post-graduate work, because of the fact that this Board did not recognize this college. It is noted that date of graduation is 1911, and this applicant did not submit himself for examination until 1919, eight years afterward. In the meantime he submitted credentials showing two years service at the New York Post-Graduate Hospital from January, 1914, to March, 1916; also service at the New York German Hospital as resident physician, March, 1916, to July, 1917; also service at the Memphis City Hospital, June, 1911, to July, 1912, and service as Medical Lieutenant in the United States Army in France, July, 1917, to February, 1919. This man became assistant to one of our older members of this Society at the time and has since left the State.

"A." A physician, a graduate of Middlesex Medical College, 1918. Passed examination before this Board in October, 1921. Given permission to take the examination in view of post-graduate work which consisted of one year of service at the Boston City Hospital, one year of service at the New York Lying-In Hospital, and fourteen months as resident physician at Blackwell's Island. Information on application blank also indicates two years at Brown University, one year at Tufts Medical College and two years at Har-

Discussed before the Rhode Island Medical Society at the quarterly meeting, December 6, 1923.

vard Medical College. This man is doing special work and consultation work.

"B." A physician a graduate of Chicago College of Medicine and Surgery, 1916. The Chicago College of Medicine and Surgery became extinct in 1917 and was rated at that time as being in class B. As the Board did not recognize class B colleges, he was allowed to take the examination in view of the fact that during the war he was drafted into the United States Army as a private. The Board took into consideration his post-graduate work, which consisted of sixteen months at St. Joseph's Hospital in Providence and allowed this applicant to submit himself for examination in view of his post-graduate work and also to put him in a position for higher rating in the army should he be fortunate in passing, which he did.

"D." A physician a graduate of Eastern University, 1913. The Maryland College of Eclectic Medicine and Surgery, Baltimore, organized in 1912 as the Eclectic School of Medicine of Milton University, but later took the title of Eastern University School of Medicine, in 1914.* Attended the Maryland Medical College three years and graduated from the Eastern University in 1913. Post-graduate work at St. Joseph's Hospital, Providence, nine months, and Robinson Memorial Hospital three months. Registered pharmacist, nine months internship Massachusetts Homeopathic Hospital. Registered in Maine, Massachusetts and Georgia. Examination allowed at the urgent solicitation of a member of the Board.

"E." Graduate of Physicians and Surgeons, 1912, class C school. Did not appear for examination until 1919. In the meantime he practiced five years in the city of Boston; 1908 to 1909, Tufts Medical. Was on the service at Rhode Island Hospital, Boston City Hospital, and Long Island Hospital. Registered in Maine in 1913, and in Massachusetts in 1912. Recommended by Mayor Gainer and Judge Gorham.

"F." Graduate of P. & S. in Boston, class 1910. Allowed to take examination after ten years had elapsed on account of his serving ten years at State Hospital for Mental Diseases at Howard.

*Subsequent to the date of this discussion it has been proven that the Eastern University School of Medicine of Baltimore took this name in 1912. The State records of Maryland prove this.

"H." A physician a graduate of Eclectic Medical College of Cincinnati, Ohio, in 1904, was allowed examination in 1922 due to the fact that he graduated 18 years previously, having had fourteen years practice in Columbus, Ohio, and three years practice in Boston, Mass. This physician is limiting his practice to X-ray work.

I will say that a special meeting of the Rhode Island State Board of Health has been held this afternoon and these cases have all been reviewed, and in the opinion of the Board there has been no attempt to misrepresent in any case except possibly one, and in that case there is certain information which we have tried to obtain before the meeting which we have not yet received. I have good reason to believe that a slight mistake has been made on the part of the Secretary of the Council on Medical Education and Hospitals of the A. M. A. in Chicago, and on account of clearing up that matter we have requested certain information, and that information not being received as yet, we have decided to postpone action until that information is obtained.

I feel, gentlemen, from the facts we are learning from various states, that ultimately we are going to find that the State Board of Health, the Examining Board of this State, has done everything in its power to attain a high standard, and we shall find that we are very fortunate in being in much better shape than they are in neighboring states. I feel, too, that this matter having been brought up is going to aid us very much in our effort to get what we have been trying to get in years past. I feel also that we are very much indebted to the courtesy of the President of this Society in asking me to come down and present this information.

Dr. Matteson: I would like to ask Dr. Richards what he meant by his expression of "established custom of requiring examination."

Dr. Richards: In 1908 a law was passed requiring that the State Board of Health examine candidates presenting diploma from schools which in its opinion are of good standing.

Dr. Skelton: I would like to ask Dr. Richards if these men have passed the examination.

Dr. Richards: Yes, they have.

Dr. Skelton: In the cases of these men whose names have been read, their hospital training is far superior to that of some men who are practicing.

ing medicine here today. In looking up the records in connection with an investigation for the Section on Medicine, I find that there are thirty-nine men in the State of Rhode Island who never saw the inside of a medical college. Certainly these men have studied some and have had good practical experience. The State Board of Health have made some concessions to these men, and I believe that a vote of confidence be extended to the State Board of Health.

Dr. Chase: The Secretary of the State Board of Health did not furnish us the information that we were looking for today. There has been a discussion on the bogus diploma. I happen to know that there have been overtures from the Connecticut Society to the Rhode Island Society. I am not interested in the men on the list. What is going to follow the investigation? What is going to become of these men who are to be ousted from Connecticut?

Dr. Barry: I understand that we are unable to get a law in the State of Rhode Island under which a great many cases may be prosecuted. I would like to ask Dr. Richards if he is able to get the Department of Law to obtain such a law.

Dr. Richards: About these men who are coming into this State possibly after having lost their practice in neighboring States. That is one of the many troubles that has not come to us yet. Of course we have been deluged with applications. These men never fail to find the very best legal talent to defend them, and the leading citizens of our State very frequently come to us with an appeal that a certain man have a license to practice medicine. The State Board of Health has never deviated in cases of that kind. There are several applicants now before the Board who applied some months ago before this question became prominent, and on consulting my files of correspondence I find that such candidates have been notified that they have not submitted sufficient evidence to come before the Board for examination. We shall certainly take action against any case that we know of.

With regard to our receiving assistance from the office of the Attorney General. I am very happy to say that we have had very cordial assistance for some years past. They are not able to deal with all the cases that are presented to them. We have an inspector whom we employ to look

these matters up, and I find that during a period of four years there have been twenty-six cases in the office of the Attorney General where evidence procured has appeared to us to be very good and as yet no action has been taken. The Attorney General's office is a very busy one, and they have not been able to get at all the cases, but on the other hand they act promptly upon a great many.

There is on the average one new case a week of violation of the Medical Practice Act investigated, and many of these offenders have left the State and many of them have been brought before the courts. Up to a very recent time it has been almost impossible to get a conviction on an abortion case, but fortunately the law has been changed so that one justice has the entire criminal work to do, and it has been a very good change of law, because now these cases can be brought up for trial more promptly, while before we were obliged to wait a couple of years sometimes, and in the meantime the witnesses died or moved and it was hard to get a conviction. That is the complaint Dr. Swarts used to make. That is not the case now. A man comes up before our criminal court judge now and he is given rather a light sentence on first offense, but the second time it is very serious. We have had a good many. One time a few years ago we had four serving in State Prison at the same time. You know just recently a fellow went back for a term of six years because after getting out of State Prison he started up in business again. Within a few days there will be two more persons brought before the courts for alleged offenses, a woman we have been after for about three years who performed an abortion in a neighboring city and ran away, has now given herself up and will come before the courts for sentence. She will probably be given a deferred sentence. We have been criticized somewhat because the Board has been satisfied with a deferred sentence. Otherwise an appeal is taken and because of dilatory methods it might be two years or more before the case would come up again, and the criminal abortionist keeps on doing his work and gives us the laugh. On account of this procedure we have been able to get the real offenders, and it is a fact that the big offenders in this way have actually left the State.

PROVIDENCE MEDICAL ASSOCIATION.

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. William B. Cutts, Monday evening, December 3, 1923, at 8:55 P. M. The records of the last meeting were read and approved.

The Standing Committee having approved the application for membership of Dr. Francis J. Higgins, the Secretary was instructed to cast one ballot for his election.

Dr. Charles B. O'Rourke having allowed his membership to lapse, but having fulfilled the requirements for re-election, the Standing Committee having approved his re-election, the Secretary was instructed to cast one ballot for his re-election.

In accordance with Article 1, Section 6, of the By-Laws, the Standing Committee presented the following nominations for officers and committees for the year 1924:

For President—George W. VanBenschoten, M. D. For Vice-President—Albert H. Miller, M.D. For Secretary—Peter Pineo Chase, M.D. For Treasurer—Charles F. Deacon, M.D. For Member of the Standing Committee for five years—William B. Cutts, M.D.

For Trustee of the Rhode Island Medical Library for one year—William F. Flanagan, M.D.

For Reading Room Committee—George S. Mathews, M.D., Herman C. Pitts, M.D., Elihu Wing, M.D.

For Delegates to the House of Delegates of the Rhode Island Medical Society—J. B. Ferguson, M.D., H. E. Harris, M.D., B. H. Buxton, M.D., P. P. Chase, M.D., I. H. Noyes, M.D., P. T. Hill, M.D., W. P. Buffum, Jr., M.D., G. R. Barden, M.D., H. G. Partridge, M.D., A. H. Ruggles, M.D., A. M. Burgess, M.D., F. V. Hussey, M.D., W. F. Flanagan, M.D., F. N. Bigelow, M.D., M. B. Milan, M.D., H. B. Sanborn, M.D.

The Secretary reported that the President, Vice-President and Secretary had called on Dr. A. C. Maynard as instructed by the last regular meeting and had informed him that he must cease his newspaper advertising or be expelled from the Association. A letter from Dr. Maynard resigning from the Association was then read, and his resignation was accepted.

Dr. Skelton read a memorial on the death of Dr. Lewis J. Frink, and it was voted to send a

copy to the family, publish in the RHODE ISLAND MEDICAL JOURNAL and file a copy in the archives.

Dr. A. T. Jones, President of the Rhode Island Medical Society, called attention to the fact that there were sixty odd members of the Providence Association not members of the State Society, and urged all these to join the State Society.

Dr. Blosser presented two cases: No. 1, a young lady who had had a large port wine nevus of the face removed by the quartz lamp; No. 2, a man with marked hyperkeratosis of the palms following prolonged and heavy arsenic dosage for psoriasis.

Dr. Herman C. Pitts then presented moving pictures of the South American trip of the American College of Surgeons last winter. These were very interesting and showed graphically the wonderful civic development of the centres of population there. Dr. Pitts' explanatory remarks were instructive and entertaining.

Meeting adjourned at 10:40 P. M. Attendance 81 members, 4 guests. Collation was served.

Respectfully submitted

PETER PINEO CHASE, *Secretary*

The Providence Medical Association held its meeting February 4, 1924, 8:45 P. M., in the Medical Library Building, with the following program:

1. Diagnosis of Pulmonary Tuberculosis, Dr. Jay Perkins.

2. Three years' work with Underweight Children, Dr. Elliott Washburn, Executive Secretary Providence Tuberculosis League.

3. The Lakeside Preventorium and the Prevention of Tuberculosis, Dr. William P. Buffum, Jr. Collation followed.

RHODE ISLAND MEDICO-LEGAL SOCIETY.

The regular January meeting of the Medico-Legal Society was held at the Medical Library, 106 Francis Street, Providence, on Thursday, January 31, 1924, at 5 P. M. Light supper at 6:30 P. M.

Dr. Byron U. Richards, Secretary of the State Board of Health, spoke upon, "The State's Problem in Regulating the Practice of Medicine."

ADDRESS

Continued from page 38

to secure payment voluntarily on the part of the customer until they come to demand for payment. We use in collection work the telephone, and in some cases outside collectors.

That briefly is the system we use in department stores. What are the results that we get? I think that may be of interest to you. The monthly collections vary from 60% to 75% of all money outstanding. I want to quote you just one figure from one of the larger department stores on conditions the last day of December. Accounts of ninety days or longer standing were less than 2% of the entire amount outstanding on the books. The amount of loss resulting from the collection system was one-fifteenth of 1%, proving that in results it pays to stick regularly to bills or monthly statements. To get results from the bill or statement it is necessary that it be sent regularly and made part and parcel of a business concern.

The Credit Men's Association will be very glad to render any help they can in recommending a bookkeeping or billing system to any of the members of the association that care to call upon them to do so, and I thank you, gentlemen, for the opportunity you have given me for being here before you tonight.

DISCUSSION OF THE PAPER ON "INTERSUSCEPTION IN ADULTS."*

(While it is quite contrary to general custom to publish the discussion of an article without the original article, the following is sufficiently interesting to warrant deviation.—Ed.)

Dr. George Matteson: Dr. Gallison's account of the conditions is very clear and frequently filled with many instances of his excellent surgical judgment, which I hope we will all keep in mind when the next occasion arises to see a case of that sort. It is a rare condition, certainly, but still among the possibilities in acute abdominal obstruction, an understanding which we must keep it in mind.

I personally have seen but one case in an adult, but in looking over such records as are available I

have found that there have been a number of cases in the period of ten years which should possibly be included.

My own case was a woman of fifty, and she illustrated a good many of the points that Dr. Gallison has brought out so well. One point in particular was the history of rather indifferent attacks of some sort of abdominal distension. Not only from the history but from the examination this woman had in the neighborhood of the gall bladder a little tumor which was exceedingly movable, such as the average gall bladder is. The woman had been sick for two days and was so desperately ill that it was not possible to get a very complete history, and it was obvious that she needed operation at once, so operation was done. Forty-two centimeters of the ileum intersuscepted into the caecum. I probably unwisely attempted dissection, and the case died.

Other points in the history of that case and in various other cases make the diagnosis indefinite and hard to arrive at. I think we all have in mind a fairly definite picture of acute intersusception in a child, with pains, early vomiting, prostration, high pulse; and one thing which stays in the mind is the currant jelly stools. In adults those very characteristic symptoms do not always appear, and when the bowels do move, it is a very normal sort of a movement. It is an evacuation of part of the intestinal contents beyond the constricted point, and that evacuation is not in any way modified by the presence of an intersusception. The stool under these circumstances is never bloody, and that symptom that means so much in the child is not the same as in an adult person.

Dr. Gallison did not speak in very much favor of the Vaca operation, which in a very recent article I read was quite highly commended. The writer of the article had done nine of them with a mortality of only two. I did not read the cases thoroughly enough to relate them here, but the fact remains that they were mostly successful. In that operation, as Dr. Gallison explained, the intersusception is turned out and resected and the intersusciens sutured together and brought to the point where the invagination has taken place. That is in effect the Vaca operation. I have never had occasion to try it, but I think I should like it.

Read by Dr. James M. Gallison, of Boston, before Providence Medical Association, November 5, 1923.

We are indebted to Dr. Gallison for his wonderfully clear and instructive paper full of practical points.

Dr. Bugbee: Mr. President, I wish to add my appreciation to Dr. Gallison for his very interesting and instructive paper. All that I was invited to discuss this for particularly was a case I had to report.

I looked at the records of the Rhode Island Hospital, and since 1920 we have had fifteen cases of intersusception, two of which occurred in adults. One of these was on medical service, and was extremely interesting; a case of an old colored man who had been getting a gradually increasing condition for three weeks. The main diagnosis on the day of admission was of intestinal obstruction. The pathological report is of double intersusception of the small bowel.

(Reads report.)

This was one of the two cases we have had there in the period of about three and a half years. The other case was a Portuguese woman.

(Reads report.)

Dr. Hussey: It has been a great pleasure to listen to Dr. Gallison's paper this evening because it has gone rather extensively into the diagnosis and treatment.

The operation for intersusception, it seems to me, is an entirely different problem in infants and adults. The question of diagnosis in infants is a question that is comparatively easy for two reasons, for in most infants we can get a palpable tumor, and we are always on the lookout for acute intersusception in all infants. In adults intersusception is so rare that we are not able to carry that in mind and consequently our diagnosis is not made until the time of operation. The question of etiology is also different. It is very seldom that we find any predisposing history in adults. In infants it is apparently due to an irregular type of peristalsis because of dietary reasons, or what not. In adults that is seldom a cause. We often find tumors or a Meckel's diverticulum which is the cause of the intersusception in adults and in infants. The predominating symptoms are the symptoms of intestinal obstruction. It is possible in adults for the intersusception to take place and persist without anything else, but those symptoms indicate more or less that the blood supply is interfered with.

In regard to the treatment, it seems to me that the question resolves itself in adults into an early diagnosis of a surgical condition. Probably 90% of these cases will not be diagnosed as intersusception before operation. Acute surgical trouble should be attacked and proper methods taken to correct it. I do not believe there is any other treatment for it but surgery. The methods of air and water distension are so antiquated that we will pass by them without any discussion of them at all. There is no treatment but surgery. The mortality depends directly on the length of time between the onset of the symptoms and the operation. The longer the interval between the onset and the operation, the greater the mortality. And also the length of time influences greatly the measure to be adopted at the operation. In a good many of these cases, in those that are operated on early, the intersusception can be reduced without any more interference. I had occasion a year ago to report a number of cases for the Memorial Hospital. We had a series of sixteen cases. The ages ranged from nine months to fifteen years. The duration of the disease before operation ranged from four hours to nine days, and it is interesting to note that the case that had been of nine days duration with an intersusception resting in the rectum almost protruding from the anus was reduced and made a perfectly good recovery.

I believe that if you get these cases early a great deal can be done, and it has been proven very conclusively. A great many cases have been getting by.

Dr. Cubbe has reported something like two hundred and fifty cases. In the first fifty cases there was a mortality of 50%, while in the last fifty the mortality was 6%. We cannot equal it in this country.

Early diagnosis and early operation is necessary. I also believe that in infants if you cannot reduce, the only thing to do is to do the most simple type of operation. Very few cases have been reported of primary intersusception with perfect result in infants. If you have had a long standing case, one that has been acute, a condition with more or less peritonitis, it should be done with a secondary operation. You will be very fortunate to get by with a primary operation. The

Continued on page XII